Department of State Health Services
Agenda Item for State Health Services Council
October 10-11, 2007

Agenda Item Title: Repeal 25 TAC, Chapter 460, Rules Relating to Miscellaneous Rules from Legacy Agencies Texas Department of Mental Health and Mental Retardation (TDMHMR) and Texas Commission on Alcohol and Drug Abuse (TCADA)

Agenda Number: 4-b

Recommended Council Action:
____For Discussion Only

__X For Discussion and Action by the Council

Background:

The repeals are necessary to eliminate duplication and to recognize the effect of House Bill 2292 on department rules. When House Bill 2292 consolidated the department's legacy agencies on September 1, 2004, Texas Administrative Code, Title 25, Part 1 was designated as the location for all department rules. Chapter 460 was designated for rules from the department's legacy agencies that could be repealed because of the provisions in House Bill 2292.

Summary:

The rules in Chapter 460 concern legacy agency powers and duties that transferred to the Texas Health and Human Services Commission (commission) through House Bill 2292, were duplicative of the law establishing the department or other law applicable to the department, or were expected to be established by department policy rather than by rule.

Summary of Stakeholder Input to Date (including advisory committees):

Office of General Counsel program attorneys for hospital licensing and compliance, mental health, and substance abuse were consulted. On September 13, 2007, the proposed rules were presented to the Medical Care Advisory Committee.

Proposed Motion: Motion to recommend HHSC approval for publication of rules contained in agenda item # **4-b**.

Agenda Item Approved by: ____Linda S. Wiegman_____

Presented by: Linda S. Wiegman_____ **Title**: Deputy General Counsel

Program/Division: OGC_ **Contact Name/Phone:** Sara Richardson, ext. 6961

Date Submitted
August 22, 2007

Title 25. HEALTH SERVICES
Part 1. DEPARTMENT OF STATE HEALTH SERVICES
Chapter 460. Miscellaneous
Subchapter A. Texas Department of Mental Health and Mental Retardation
Division 2. Fraud and Abuse and Recovery of Benefits
Repeal §§460.11 – 460.29
Division 3. Interagency Agreements
Repeal §§460.31 – 460.35, 460.37 – 460.38, 460.40, 460.45
Division 4. Internal Audits and Investigations
Repeal §§460.51 – 460.67
Subchapter B. Procurement
Repeal §§460.101 – 460.102
Subchapter C. Miscellaneous Provisions
Repeal §§460.103 – 460.105

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission (commission) on behalf of the Department of State Health Services (department) proposes the repeal of 25 Texas Administrative Code (TAC), Chapter 460, Miscellaneous, in its entirety. Specifically, the department proposes the repeals of §§460.11 – 460.29, 460.31 – 460.35, 460.37 – 460.38, 460.40, 460.45, 460.51 – 460.67, 460.101 – 460.102, and 460.103 – 460.105 concerning miscellaneous rules from the legacy agencies that were consolidated into the department by Acts 2003, 78th Legislature, Regular Session, Chapter 198 (House Bill 2292).

BACKGROUND AND PURPOSE

The repeals are necessary to eliminate duplication and to recognize the effect of House Bill 2292 on department rules. When the department's legacy agencies Texas Department of Health (TDH), the mental health division of the Texas Department of Mental Health and Mental Retardation (TDMHMR), the Texas Commission on Alcohol and Drug Abuse (TCADA), and the Texas Health Care Information Council (THCIC) were consolidated into the department, 25 TAC, Part 1 was designated as the location for all department rules. Chapter 460 was designated for rules from the department's legacy agencies that did not need to be retained. The rules in Chapter 460 concern legacy agency powers and duties that transferred to the commission through House Bill 2292, were duplicative of the law establishing the department or other law applicable to the department, or were expected to be established by department policy rather than by rule. The rules in Chapter 460 were transferred there in 2004 with the intent of eventual repeal.

SECTION-BY-SECTION SUMMARY

The rules in Chapter 460, Subchapter A, Divisions 2 – 4 are legacy TDMHMR rules. Repeal of Division 2, §§460.11 – 460.29, Fraud and Abuse and Recovery of Benefits, is necessary because powers and duties concerning Medicaid fraud and abuse investigation and recovery were transferred from the legacy agencies to the commission, Office of Inspector General (OIG), on

September 1, 2004, pursuant to House Bill 2292. Some of the sections in Division 2 are internal policies and procedures that do not need to be in rules. The sections concerning grounds for sanctions against providers, grounds for further referrals for administrative or judicial action, and the recovery of overpayments are set out in the contracts with providers and in the OIG rules. The OIG rules, which were adopted effective January 9, 2005, are located in the 1 TAC, Part 15, Chapter 371.

Repeal of Division 3, §§460.31 – 460.35, 460.37 – 460.38, 460.40, and 460.45, Interagency Agreements, is necessary because those legacy TDMHMR rules are duplicative of department rules or policies. The sections in Division 3 all were transferred effective September 1, 2004 from Texas Administrative Code, Title 25, Chapter 411 to Chapter 460. Section 460.31, Purpose, §460.32, Applications, and §460.33, Definitions, are unnecessary because they refer to the legacy agency TDMHMR, which no longer exists. Section 460.34, concerning Provision, Regulation, and Funding of Services in Hospitals and Long-Term Care Facilities, is duplicative because a rule adopting this memorandum of understanding (MOU) is already found at 25 TAC §111.2. State law requires the MOU to be adopted by rule. Section 460.35, concerning Coordination of Services to Disabled Persons, is duplicative because a rule adopting this MOU is already found at 25 TAC §1.121. State law requires the MOU to be adopted by rule. Section 460.37, concerning Coordination of Delivery of Mental Health and Mental Retardation Services to Hearing-Impaired or Deaf Persons, is duplicative because a rule adopting this MOU is already found at 25 TAC §37.193. State law does not require the MOU to be adopted by rule. Section 460.38, concerning Coordination of Exchange and Distribution of Public Awareness Information, is duplicative because a rule adopting this MOU is already found at 25 TAC §1.101. State law requires the MOU to be adopted by rule. Section 460.40, concerning Training Requirements for Identifying Abuse, Neglect, and Unprofessional or Unethical Conduct in Health Care Facilities is duplicative because department rules adopting this MOU or incorporating its requirements are already found at 25 TAC §§133.47, 134.46, 411.490, 411.641, and 448.603. Section 460.45, Distribution, is duplicative because the distribution requirements for the MOUs are found in internal department policies.

Repeal of Division 4, §§460.51 – 460.67, Internal Audits and Investigations, is necessary because the department's internal and external audit powers and duties reside in policy rather than in rule. The Texas Internal Auditing Act, found in Texas Government Code, Chapter 2102, does not require agencies to adopt rules for internal auditing practices.

Repeal of the rules in Chapter 460, Subchapter B, §§ 460.101 – 460.102, Procurement, and Subchapter C, §§460.103 – 460.105, Miscellaneous Provisions, is necessary because the sections in both subchapters are legacy TCADA rules concerning powers and duties which either were transferred to the commission in House Bill 2292, exist elsewhere in state law or department or commission rules, reside in department policy rather than in rule, or refer to legacy agency TCADA. Section 460.101, Procurement, and §460.102, Procurement Protests, are redundant because they are part of the requirements placed on health and human services agencies by state law at Texas Government Code, §2155.144, Procurements by Health and Human Services Agencies; commission procurement rules found in 1 TAC, Chapter 391; state law and Texas Building and Procurement Commission rules concerning historically underutilized businesses

(HUB); and current department rules concerning HUBs at 25 TAC §1.171. Sections 460.103 – 460.105 are rules specific to TCADA, which no longer exists.

FISCAL NOTE

Linda S. Wiegman, Deputy General Counsel, has determined that for each year of the first five years the sections are in effect, there will be no fiscal implications to state or local governments as a result of repealing the sections as proposed.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Wiegman has also determined that there will be no effect on small businesses or micro-businesses as a result of the proposed repeals. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices since the rules set out requirements for the department, not for such businesses. There are no anticipated economic costs to persons as a result of the proposed repeals. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

In addition, Ms. Wiegman has also determined that for each year of the first five years the proposed repeals are in effect, the public will benefit from adoption of the repeals. The public benefit anticipated as a result of the proposed repeals is compliance with House Bill 2292 and to eliminate confusion concerning the department’s rules.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed repeals do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Sara Richardson, Office of General Counsel, Department of State Health Services, 1100 West 49th Street, Austin, Texas 78756, 512/458-

7111, extension 6961 or by email to sara.richardson@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed repeals are authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The proposed repeals affect the Health and Safety Code, Chapter 1001; and Government Code, Chapter 531.

Sections for repeal:
§460.11. Department Responsibility for Minimizing Fraud and Abuse.
§460.12. Confidentiality of Fraud or Abuse Investigation Records.
§460.13. Statutory Bases.
§460.14. Department Responsibilities in Relation to Provider Fraud and Abuse.
§460.15. Grounds for Fraud Referral and Administrative Sanction.
§460.16. Administrative Sanctions/Actions, Restitution, and Recoupment.
§460.17. Definitions.
§460.18. Administrative Sanctions and Actions.
§460.19. Scope of Sanction.
§460.20. Imposing a Sanction.
§460.21. Notice of Adverse Action.
§460.22. Informing Other Interested Parties.
§460.23. Provider Education.
§460.24. Request for Reinstatement.
§460.25. Obligation of Health Care Practitioners and Providers.
§460.26. Department Responsibility for Recovery of Funds.
§460.27. Recovery from Providers.
§460.28. Recovery When Fraud Is Involved.
§460.29. Provider Re-enrollment or Provider Contract or Agreement Modification.
§460.31. Purpose.
§460.32. Application.
§460.33. Definitions.
§460.34. Memorandum of Understanding: Provision, Regulation, and Funding of Services in Hospitals and Long-Term Care Facilities.
§460.35. Memorandum of Understanding: Coordination of Services to Disabled Persons.

§460.37. Memorandum of Understanding: Coordination of Delivery of Mental Health and Mental Retardation Services to Hearing-Impaired or Deaf Persons
§460.38. Memorandum of Understanding: Coordination of Exchange and Distribution of Public Awareness Information.
§460.40. Training Requirements for Identifying Abuse, Neglect, and Unprofessional or Unethical Conduct in Health Care Facilities.
§460.45. Distribution.
§460.51. Purpose.
§460.52. Application.
§460.53. Definitions.
§460.54. Office of Internal Audit Authority and Function.
§460.55. Responsibilities of the Audit Committee Chairman and the TDMHMR Board.
§460.56. Responsibilities of the Director.
§460.57. Access to Records.
§460.58. Standards of Conduct.
§460.59. Standards for Conducting Audits and Investigations.
§460.60. Scope of Audit Work.
§460.61. Exit Conference Procedures for Audits.
§460.62. Responses to Audit Findings.
§460.63. Final Audit Report Distribution.
§460.64. Implementing Audit Recommendations.
§460.65. Investigating Alleged Fraud, Misconduct, or Other Wrongdoing.
§460.66. References.
§460.67. Distribution.
§460.101. Procurement.
§460.102. Procurement Protests.
§460.103. Public Comment and Requests.
§460.104. Approval Authority.
§460.105. Training and Education.

Legend:
~~Strikethrough~~ = Language being repealed

~~§460.11. Department Responsibility for Minimizing Fraud and Abuse~~

~~(a) The Texas Department of Mental Health and Mental Retardation is responsible for minimizing the opportunity for provider fraud and abuse as well as recipient fraud and abuse and for protecting recipients of federally funded health care programs from unsafe practitioners. The department takes appropriate action to protect recipients and the program when providers of services are suspected of committing fraud or abuse.~~
~~(b) All actions resulting in overpayment to a provider are not necessarily fraudulent. Some circumstances could result in the referral of a provider to the Medicaid Fraud Control Unit in the attorney general's office. Other circumstances would result in administrative action rather than referral for judicial action or criminal prosecution. These actions, or sanctions, range from a notice to the provider explaining his error to exclusion from the Medicaid program.~~

~~§460.12. Confidentiality of Fraud or Abuse Investigation Records~~

~~Requests for disclosure or copies of information regarding fraud or abuse investigations are treated as confidential, and records may not be disclosed under the Open Records Act or otherwise without first coordinating the requests with the Office of the General Counsel and the Fraud and Abuse Division.~~

~~§460.13. Statutory Bases~~

~~The statutory bases for Medicaid fraud and abuse investigation and prosecution are the Texas Human Resources Code, Chapter 32, and 42 United States Code §1396b(q) and §1396h. State and federal officials may also act under other statutes including, but not limited to, the Deceptive Trade Practices and Consumer Protection Act, the Texas Penal Code, the Civil Monetary Penalties Law, and Public Law 100-93.~~

~~§460.14. Department Responsibilities in Relation to Provider Fraud and Abuse~~

~~The department's responsibilities in relation to provider fraud and abuse include the following:~~

~~(1) establishing criteria for identifying cases of possible fraud or abuse;~~
~~(2) establishing the methods for referring suspected fraud cases for investigation;~~
~~(3) cooperating with the Medicaid Fraud Control Unit, Office of the Attorney General, by furnishing information and data and serving as witnesses, when requested;~~
~~(4) recouping all overpayment and taking other administrative sanctions and actions; and~~
~~(5) investigating cases of possible abuse.~~

~~§460.15. Grounds for Fraud Referral and Administrative Sanction~~

~~The department may impose sanctions against a provider or a provider's employee who permits, does, or causes any of the following items or for any other reason provided by law or duly issued regulation. This list is not all-inclusive. These reasons could include, but are not limited to:~~

~~(1) submitting a false statement or misrepresentation, or omitting pertinent facts when claiming payment under Medicaid or when supplying information used to determine the right to payment under Medicaid;~~
~~(2) submitting a false statement, information, or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;~~
~~(3) submitting a false statement, information, or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;~~
~~(4) failing to disclose or make available upon request to the department or its authorized agents, representatives of the Department of Health and Human Services, or the attorney general's Medicaid Fraud Control Unit any records the provider is required to maintain or any records necessary to verify items or services furnished under Title XIX or Title XX to determine whether payment for those items or services is due or was properly made. This includes providing documentation or allowing examination of records or both. This also includes records of services provided to Medicaid recipients and payments made for those services, including, but not limited to, documents related to diagnosis, treatment, service, lab results, and x-rays. Accessible information must include information that is necessary for the agencies specified in this paragraph to perform statutory functions;~~
~~(5) failing to provide and maintain quality services to Medicaid recipients within accepted medical community standards or standards required by statute, regulation, or contract;~~
~~(6) failing to comply with the terms of the Medicaid contract or provider agreement, assignment agreement, the provider certification on the Medicaid claim form, or regulations published by the department;~~
~~(7) furnishing or ordering services to patients (whether or not eligible for benefits under Title XVIII or a state health care program) that substantially exceed the recipient's needs, are not medically necessary, are not provided economically, or are of a quality that fails to meet professionally recognized standards of health care;~~
~~(8) rebating or accepting a fee or part of a fee or charge for a Medicaid patient referral;~~
~~(9) violating any provision of the Human Resources Code, Chapter 32, or any rule or regulation issued under the Code;~~
~~(10) submitting a false statement or misrepresentation or omitting pertinent facts on any application or any documents requested as a prerequisite for Medicaid participation;~~
~~(11) failing to meet standards required for licensure or required by state or federal law, department rule, provider agreement, or provider manuals for participation in the Medicaid program;~~
~~(12) charging recipients for allowable services that exceed the amount the department or its agents pay for except when specifically allowed by the department;~~
~~(13) refusing to execute or comply with a provider agreement or amendments when requested;~~
~~(14) failing to correct deficiencies in provider operations after receiving written notice of them from the department or its authorized agents;~~
~~(15) engaging in any negligent practice resulting in death, injury, or substantial probability of death or injury to the provider's patients and to persons who receive or benefit from the provider's services;~~

~~(16) pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, the Texas Medicaid program, or any other state's Medicaid program;~~
~~(17) failing to repay or make arrangements that are satisfactory to the department to repay identified overpayment or other erroneous payments;~~
~~(18) failing to abide by applicable statutes regarding handicapped individuals or civil rights;~~
~~(19) being terminated, suspended, or excluded from participation in any federal program, having an unpaid debt under any federal program, or being otherwise sanctioned under any federal program involving the provision of health care, including the Department of Defense, the Veterans Administration, and any state health care program for actions or failure to act that would be considered abusive or fraudulent. This includes any reasons related to the person's professional competence or performance or financial integrity. Any appeal by the provider for an action taken against him under this item does not consider the validity of a sanction or action taken by Medicare or any other state's Medicaid program;~~
~~(20) submitting or causing to be submitted under Title XVIII or a state health care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients;~~
~~(21) failing to comply with Medicaid policies, published Medicaid bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or previously sent interpretations to the provider of any of the items listed;~~
~~(22) submitting claims with a pattern of inappropriate coding or billing that results in excessive costs to the Medicaid program;~~
~~(23) billing for services or merchandise that was not provided to the recipient;~~
~~(24) submitting to the Medicaid program a cost report containing costs not associated with the Medicaid program or not permitted by Medicaid program policies;~~
~~(25) submitting a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;~~
~~(26) charging recipients for services when payment for the services was recouped by Medicaid because of any of the reasons stated in 40 TAC §79.2303;~~
~~(27) failing to notify and reimburse the department or its agents for services paid by Medicaid if the provider also receives reimbursement from a liable third party;~~
~~(28) misapplying, misusing, embezzling, failing to promptly release upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Medicaid recipient;~~
~~(29) pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;~~
~~(30) pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude;~~
~~(31) having a voluntary or involuntary action taken by a licensing agency or board to require the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing requirements;~~
~~(32) pleading guilty or being convicted of a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of a health care item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency;~~

~~(33) being convicted in connection with the interference with or obstruction of any investigation into any criminal offense described in §409.58(f) of this title (relating to Administrative Sanctions or Actions) or paragraphs (16), (29), (30), or (32) of this section;~~
~~(34) having its license to provide health care revoked or suspended by any state licensing authority, or losing this license because of action based on assessment of the person's professional competence, professional performance, or financial integrity, or surrendering this license while a formal disciplinary proceeding is pending before licensing authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity;~~
~~(35) substantially failing, as a health maintenance organization under Title XIX or any entity furnishing services under waiver granted by the United States Department of Health and Human Services (DHHS) under that title, to provide medically necessary items or services that are required under law or under contract, if the failure has adversely affected or is substantially likely to adversely affect the Medicaid recipient of these items or services;~~
~~(36) substantially failing, as an eligible organization under a risk-sharing contract as defined in 42 United States Code Annotated §1395mm, to provide medically necessary items or services that are required under law or contract, if the failure has adversely affected or has the potential to adversely affect the patient;~~
~~(37) committing an act described in the Social Security Act, §1128A or §1128B;~~
~~(38) meeting any of the conditions specified in 40 TAC §79.2112(f) or (g) concerning Administrative Sanctions or Actions;~~
~~(39) failing to fully and accurately make any disclosure required by the Social Security Act, §1124 or §1126;~~
~~(40) failing to disclose information about the ownership of a subcontractor with whom the person has had business transactions in an amount exceeding $25,000 during the previous 12 months or about any significant business transactions (as defined by the Health and Human Services Commission (HHSC)) with any wholly owned supplier or subcontractor during the previous five years;~~
~~(41) failing, as a hospital, to comply substantially with a corrective action required under the Social Security Act, §1886(f)(2)(B);~~
~~(42) defaulting on repayments of scholarship obligations or items relating to health profession education made or secured, in whole or in part, by HHSC when HHSC has taken all reasonable steps available to HHSC to secure repayment; or~~
~~(43) developing false source documents or failing to sign source documents, to retain supporting documentation, or to comply with the provisions or requirements of the department pertaining to electronic claims submittal.~~

~~§460.16 Administrative Sanctions/Actions, Restitution, and Recoupment~~

~~The department exercises authority for recoupment and restitution of overpayment to providers in all medical programs. The department or its agents can collect the money involved. The department also has the authority to impose administrative sanctions and actions against a provider when violations, as listed in this subchapter and other applicable sections, have occurred. For purposes of the sections in this subchapter and 40 TAC §79.2305, the provider is responsible for his own actions as well as the actions of the provider's agents.~~

§460.17. Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Abuse--Provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in unnecessary program cost or in reimbursement for services that are not medically necessary; do not meet professionally recognized standards for health care; or do not meet standards required by contract, statute, regulation, or previously sent interpretations to the provider of any of the items listed.
(2) Act--The Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93).
(3) Affiliates--Persons associated with one another so that any one of them directly or indirectly controls or has the power to control another in whole or in part.
(4) Agent--Any person, company, firm, corporation, employee, independent contractor, or other entity or association acting for or in the place of the department or a provider under authority of the department or a provider.
(5) Civil monetary penalty law--Any state or federal law permitting or requiring assessment of penalties and/or damages against individuals or entities or both for conduct that includes a claim or request for payment under Titles XVIII, XIX, or XX; and that violates the federal and/or state statutes and regulations enacted pursuant to these titles.
(6) Closed-end provider agreement--An agreement for a specific period of time. It must be renewed for the provider to continue to participate in the Medicaid program.
(7) Controlled substances--"Controlled substance" as defined by the Texas Controlled Substances Act (Texas Civil Statutes, Article 4476-15) or its successor and the Federal Controlled Substances Act (21 United States Code Annotated 8.01 et seq.) or its successor.
(8) Conviction or convicted--A person is considered to have been convicted of a criminal offense when:
(A) a judgment of conviction has been entered against him by a federal, state, or local court, regardless of whether an appeal is pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
(B) he has been found guilty by a federal, state, or local court;
(C) he has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
(D) he has entered a first-offender or other program and judgment of conviction has been withheld.
(9) Department--The Texas Department of Mental Health and Mental Retardation (TXMHMR) or its designee.
(10) Division administrator--The administrator for a division of the department administering a Title XIX or XX service.
(11) Exclusion--The temporary barring or permanent exclusion of a person from participation in the Titles XIX and XX programs, which includes barring the person from providing, ordering, or prescribing items or services for Titles XIX and XX recipients. This includes the termination of the provider contract/agreement with the excluded person.
(12) False statement or misrepresentation--Any statement or representation that is inaccurate, incomplete, or not true.

~~(13) Federal financial participation (FFP)--Federal dollars used for the administration of benefit programs.~~
~~(14) Fraud--Any act that constitutes fraud under applicable federal or state law, including any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person.~~
~~(15) Fraud and Abuse Division--The division within the Texas Department of Health charged with completing integrity reviews on potential Medicaid provider fraud or abuse cases and full investigations on provider abuse cases.~~
~~(16) Inpatient institutional services--Inpatient services provided by hospitals and long-term care facilities.~~
~~(17) Licensing authority adverse action--Action by a state or federal licensing entity (including other similar authority) against conduct that adversely affects the status of the license. Action includes revocation or suspension of a license, reprimand, censure, or probation.~~
~~(18) Open-end provider agreement--An agreement that has no specific termination date and continues in force as long as both parties agree.~~
~~(19) Overpayment--The amount paid to a provider that exceeds the amount to which the provider is entitled for a particular service. Overpayment may result from any of the following which are not intended to be all inclusive: a false statement or misrepresentation, an omission of pertinent information, or the lack of sufficient supporting documentation for the service. This does not include claims processing errors made by the department or its agents, although these are subject to recoupment.~~
~~(20) Person--An individual, association, partnership, corporation, or other organization or legal entity that has or has had a contract or provider agreement with the department or has been or is an employee of a Title XVIII or any state's Title XIX, XX, or V provider.~~
~~(21) Practitioner--A physician or other individual licensed under state law to practice his profession.~~
~~(22) Provider--A person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the department to provide medical assistance under contract or provider agreement with the department.~~
~~(23) Recipient--A person eligible for and covered by the Texas Medical Assistance Program.~~
~~(24) Recoupment of overpayment--A reduction or an adjustment of the amounts paid to a provider or collection of funds on previously submitted pending and subsequently submitted bills to offset overpayment previously made to the provider.~~
~~(25) Restricted reimbursement--Denial of payment for specific procedures for a specified time period for services that the provider has abused or has billed inappropriately.~~
~~(26) State health care program--Any program that has a state plan approved under Title XIX or any program that receives funds or allotments in any state under Title V or XX of the Social Security Act.~~
~~(27) Suspension of payments (payment hold)--The withholding of all or any portion of payments due a provider until the matter in dispute between the provider and the department or agent is resolved.~~
~~(28) Texas Department of Mental Health and Mental Retardation--The Texas Department of Mental Health and Mental Retardation or its designee.~~
~~(29) Title XIX--Title XIX (Medicaid) of the Social Security Act.~~
~~(30) Title XVIII--Title XVIII (Medicare) of the Social Security Act.~~
~~(31) Title XX--Social Services Block Grant of the Social Security Act.~~

~~(32) TXMHMR--The Texas Department of Mental Health and Mental Retardation or its designee.~~
~~(33) Unit--The Medicaid Fraud Control Unit within the attorney general's office that is responsible for investigating all potential Medicaid provider fraud cases and cases involving physical abuse of patients in institutional settings.~~

~~§460.18--Administrative Sanctions and Actions~~

~~(a) The following sanctions may be imposed against providers for any reason specified in §409.55 of this title (relating to Grounds for Fraud Referral and Administrative Sanction):~~
~~(1) exclusion from participation in the Titles XIX and XX programs for a specified period of time;~~
~~(2) suspension of payments (payment hold) to a provider;~~
~~(3) recoupment of overpayment;~~
~~(4) recoupment of overpayment projected from a sampling process; and~~
~~(5) restricted reimbursement from the Titles XIX and XX programs for a specified period of time.~~
~~(b) A sanction may be imposed even if none of the administrative actions listed in subsection (c) of this section has been imposed.~~
~~(c) Administrative actions may be imposed against providers and may include, but are not limited to, the following:~~
~~(1) referral to peer review outside the department;~~
~~(2) transfer to a closed-end provider agreement for a specified period of time;~~
~~(3) attendance at provider education sessions;~~
~~(4) prior authorization of selected services;~~
~~(5) review of all services before payment;~~
~~(6) review of all services after payment;~~
~~(7) referral to the appropriate state licensing board;~~
~~(8) referral to the Department of Health and Human Services, including referral for action under the civil monetary penalties law (the Social Security Act, §1128);~~
~~(9) attendance in informal or formal provider corrective action meetings;~~
~~(10) submittal of additional justification that is not normally required to accompany submitted claims;~~
~~(11) oral, written, or personal educational contact with the provider;~~
~~(12) posting of a surety bond; and~~
~~(13) referral for recovery through judicial means of all overpayment.~~
~~(d) The department must exclude providers from participation in the Titles XIX and XX programs for at least the period of time directed by the Department of Health and Human Services. Additionally, the department excludes from participation in the Titles XIX and XX programs, for a minimum period of one year beyond the exclusion, commensurate with the severity of the offense, any person excluded for fraud or abuse or under the provisions allowed in the Act.~~
~~(e) Providers are afforded all administrative and judicial due process remedies applicable to administrative actions and sanctions as specified in Subchapter B of this chapter (relating to Contract Appeals).~~

(f) The department must exclude from participation in Titles XIX and XX programs for a minimum of five years any person who has been convicted under federal or state law of a criminal offense related to:

(1) delivery of an item or service under Title XVIII (Medicare) or under any state health care program; or

(2) neglect or abuse of patients in connection with the delivery of a health care item or service.

(g) The department may exclude a partnership, corporation, association, or other legal entity in which an individual, who has an ownership or controlling interest in that entity as defined in the Social Security Act, §1124(a)(3), or is an officer, director, agent, or managing employee in that entity as defined in the Social Security Act, §1126(b), has been:

(1) convicted of any offense described in subsection (f) of this section or §409.55(16), (29), (30), or (32) of this title (relating to Grounds for Fraud Referral and Administrative Sanction);

(2) assessed with a civil monetary penalty under the Social Security Act, §1128A; or

(3) excluded from participation under a program under Title XVIII or under a state health care program.

§460.19 Scope of Sanction

(a) A sanction may be applied to all affiliates of a provider after considering all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be attributed to a provider's affiliate if the affiliate knew or approved of the misconduct within the course of his official duty.

(b) When a person is excluded under the provisions of §409.55 of this title (relating to Grounds for Fraud Referral and Administrative Sanction), he must neither personally nor through a clinic, group, corporation, or other association bill or receive payment for any Title XIX or XX services or supplies provided on or after the date of the exclusion. Additionally, he must not order or prescribe services to Title XIX or XX recipients after that date. A clinic, group, corporation, or other association that is a provider is not permitted to submit claims for any services or supplies provided by a person within the organization who is excluded from participation unless the services or supplies are provided before the exclusion effective date. A provider is not permitted to include in a cost report or any documents used to determine an individual payment rate, a statewide payment rate, or a fee, the salary, fringe, overhead, or any other costs associated with any employee, owner, officer, director, board member, independent contractor, or agent associated with the provider who was previously excluded from the Medicare or Medicaid program for program abuse. Under certain circumstances, depending upon the reason for exclusion, the department does not permit the excluded physician or individual to act as a stockholder owning 5.0% or more ownership interest, officer, director, board member, independent contractor, manager, consultant, employee providing or billing for services provided to Title XIX or XX recipients, or agent associated with a Title XIX or XX provider. Additionally, the department may exclude a Title XIX or XX provider who knowingly and willingly uses a person or entity as an employee, independent contractor, or agent who was previously excluded under these provisions.

(c) If any of the rules in this subchapter and 40 TAC §79.2305; state or federal law; provider agreements, provider manuals, or Medicaid bulletins are violated, the department may exclude the organization and any person in the organization who is responsible for the violation.

(d) To be readmitted, the provider must reapply for participation after exclusion. The department or its agent considers the merits of the case.
(e) Except as specified in subsection (f) of this section, no Title XIX or XX payments are made for services or supplies provided by participating providers that have been prescribed or ordered by an excluded practitioner on or after the effective date specified by the department. This date is subsequent to the actual effective date of the provider exclusion unless the provider's license to practice has been canceled, in which case nothing can be ordered or prescribed after license cancellation. The following criteria are used to determine when payments begin to be denied.
(1) If the department excludes under its own authority and the excluded provider fails to appeal, payments are denied 45 days from the date the excluded provider's right to appeal expires.
(2) If the department excludes under its own authority and the excluded provider appeals within the time allowed, payments are denied 45 days from the date of the administrative law judge's final decision.
(3) If the department excludes under a mandate by the Department of Health and Human Services, and federal financial participation (FFP) is denied, payments are denied 45 days from the date of exclusion. When FFP is denied, the state statute postponing the exclusion until after disposition of the appeal does not apply.
(f) An order or prescription written before the exclusion of a practitioner is valid for the duration of the order except as specified in subsection (h) of this section.
(g) If, after the effective date of an exclusion, the excluded person submits claims for which payment is prohibited, he may be subject to a civil monetary penalty under the authority contained in 42 United States Code 1329a-7a or 40 TAC §79.2402.
(h) Unless the department determines that the health and safety of patients receiving services warrants an earlier exclusion effective date, under the following circumstances an exclusion does not apply to payments made under Title XIX or XX until 30 days after its effective date:
(1) inpatient institutional services furnished to an individual who was admitted to the institution before the effective date of the exclusion; and
(2) home health services and hospice care furnished to an individual under a plan established before the effective date of the exclusion.
(i) In the event that an individual is excluded under §409.55(4) of this title (relating to Grounds for Fraud Referral and Administrative Sanction), the period of the exclusion is equal to the sum of:
(1) the length of the period in which the individual failed to grant the immediate access; and
(2) an additional period, not to exceed 90 days, set by the department.

§ 460.20 Imposing a Sanction

The decision to impose a sanction or make a fraud referral is at the discretion of the deputy commissioner or designee responsible for the program area affected by the violation. In determining the sanction to be imposed, the decision-maker may consider the seriousness of the program violation, the extent of the violation, prior imposition of sanctions, willingness to comply with program rules, recommendations of peer review groups, or any other pertinent information.

§460.21 Notice of Adverse Action

(a) Except in the following circumstances, the department sends the provider prior written notification about its intent to impose an exclusion sanction and includes a time frame for the provider to take action necessary to correct the problem areas:
(1) any criminal conduct;
(2) any action by the federal government that would preclude federal financial participation (FFP);
(3) any conduct or omission of conduct that presents a significant health, safety, or security hazard to a recipient receiving services from the provider;
(4) any conduct or omission of conduct that causes financial loss to a recipient receiving services from the provider if the financial loss is caused by a violation of the requirements of the Texas Medicaid program;
(5) any conduct or omission of conduct by the provider that indicates a pattern of repeated violations of the Texas Medicaid program;
(6) any conduct or omission of conduct by the provider that causes a significant loss of department funds paid for services not provided or not provided according to the requirements of the Texas Medical Assistance Program;
(7) any conduct or omission of conduct by the provider that would preclude the department or its authorized agents, representatives of the Department of Health and Human Services, or the attorney general's Medicaid Fraud Control Unit from obtaining upon request access to or copies of records of services provided to Medicaid recipients and payments made for those services including, but not limited to, documents related to diagnosis, treatment, service, lab results, and x-rays.
(b) When the department or its agent has notified a provider about a violation or an overpayment, future payments may be withheld on pending and subsequently received claims or all payments may be suspended pending a final determination. Recovery of overpayment may be calculated by applying a percentage, determined through sampling methods, to the total claims paid for a particular service for a specified period of time.
(c) When the department decides to sanction a provider under §409.58(a) of this title (relating to Administrative Sanctions and Actions), the provider is notified in writing. The notice includes a statement of the provider's right to request a formal review of the decision. Formal reviews are requested according to policies and procedures outlined in the department's legal services rules and procedures in the various program provider handbooks.
(d) Providers may request informal reviews of the department's or its agent's action regarding claims payment or administrative actions under §409.58(c) of this title (relating to Administrative Sanctions and Actions).
(e) Letters notifying providers about exclusion must contain a description of the duration of the action and the method the provider uses to request reinstatement.

§460.22 Informing Other Interested Parties

(a) When a provider has been excluded, the department notifies, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies about the findings made and the actions imposed according to federal requirements of the Act.
(b) The department also notifies providers, recipients, and the public about providers being excluded, through procedures established by the department.
(c) All department offices that maintain provider lists are promptly notified.

§460.23. Provider Education

Except when an exclusion is imposed, each person who is sanctioned or is seeking reinstatement may be asked to participate in a provider education program. These educational meetings are arranged by the division administrator or designee and are held at a location designated by the department.

§460.24. Request for Reinstatement

After the exclusion period specified by the department, the provider or entity may request reinstatement as specified in the notification letter. The department determines the need for individual provider participation or reinstatement. The request for reinstatement could result in a denial by the department. This determination is based on the following criteria:

(1) accessibility of other health care to the recipient population; and
(2) the provider's previous conduct, including conduct during participation in the Titles XVIII, XIX, XX, and V programs in any state, or any conduct or action for which a sanction could have been taken, as described in these sections or §409.55 of this title (relating to Grounds for Fraud Referral and Administrative Sanctions) or 40 TAC §79.2402.

§460.25. Obligation of Health Care Practitioners and Providers

(a) Each provider is responsible for ensuring that items or services furnished personally by, at the medical direction of, or on the prescription or order of an excluded physician are not billed to the Titles XIX and XX programs after dates specified in this subchapter.
(b) Providers must not bill recipients for services or items specified in subsection (a) unless:
(1) the recipient is informed, before delivery of the item or service, that those services are not reimbursed by the department; and
(2) the provider obtains and retains before delivery of the item or service a signed consent from the recipient indicating that the recipient understands he is responsible for the payment of these services and that he still requests the service.
(c) Providers who violate department rules by billing recipients are subject to all applicable administrative sanctions described in this subchapter.

§460.26. Department Responsibility for Recovery of Funds

(a) The department or its agents are responsible for recovering from providers all payments made for services delivered or provided under fraudulent or abusive circumstances or through error or misunderstanding. At the department's discretion, overpayment may be collected in a lump sum or in installments. If collection is made through installments, the provider must comply with the payment plan established by the department for a reasonable length of time not to exceed 12 months.
(b) The department determines the need for individual provider participation or reinstatement. This determination is based on the following criteria:
(1) accessibility of other health care to the recipient population; and

~~(2) previous conduct of the provider during participation in the Medicare or Medicaid program in any state or any conduct or action for which a sanction as described in these rules could have been taken.~~
~~(c) The department or its agents recover overpayment made because of claims processing errors by the department or its agents.~~

~~§460.27. Recovery from Providers~~

~~(a) Overpayment involving possible fraud are referred to the attorney general's Medicaid Fraud Control Unit. If intent to defraud is not determined or cannot be proven, the department or its agents may take an administrative sanction to recoup overpayment. Recovery of the overpayment from a provider who made a false statement or misrepresentation or who omitted pertinent facts may include the cumulative dollar amount due. The following situations are not intended to be all-inclusive.~~
~~(1) An ordering provider causes an overpayment to be made to himself or to another provider as a result of a false statement, misrepresentation, or omission of pertinent facts on a claim, attachments to a claim, medical records, or any other documentation used to adjudicate a claim for payment; any documentation submitted or maintained by the provider to support payment on individual claims or to support representations made on cost reports; or other documents used to establish fees, daily payment rates, or vendor payments.~~
~~(2) A provider makes a false statement, a misrepresentation, or omits pertinent facts on a provider agreement or any documents required as a prerequisite for Medicaid participation.~~
~~(b) The Medicaid Fraud Control Unit is primarily responsible for obtaining and reporting restitution in fraud court cases. If a particular case involves both judicial and administrative processes, the judicial process takes precedence. The unit is responsible for arranging repayment terms in fraud cases of court-ordered restitution. The department may take any other administrative sanction or action pertinent to the violation.~~
~~(c) The department may recover funds when no actual overpayment was made. The following instances are not intended to be all-inclusive:~~
~~(1) recovery of a patient's trust fund money for distribution to appropriate recipients or their responsible parties if those funds were misapplied, misused, or embezzled; or the provider is required to make this distribution;~~
~~(2) recovery of funds previously collected by the provider from recipients if collection is not allowed by contract, statute, regulation, rules, provider policy or procedure manuals, published Medicaid bulletins, policy notification letters, or interpretations previously sent to the provider;~~
~~(3) recovery of the cost of a contract appeals hearing from the provider if the department's action is upheld by the final decision of the contract appeals committee. For the purpose of this paragraph, cost of a contract appeals hearing is defined as the total cost for the court reporter and any transcripts and copies developed in preparation for, during, or after the hearing; and~~
~~(4) recovery of an unpaid debt plus interest, if any, owed to any state Medicaid or Medicare program as the result of fraudulent or abusive actions by the provider. The department distributes the balance of the recovered amount to the state Medicaid or Medicare program after recovering any administrative costs associated with the recovery. Any appeal by the provider is based solely upon whether there is or is not an unpaid balance owed to the state Medicaid or Medicare program in question.~~

~~§460.28 Recovery When Fraud Is Involved~~

~~(a) Decision to recover funds.~~
~~(1) Recovery of funds which are obtained through fraudulent means by a provider may be recommended by the prosecuting attorney or by an administrative determination by program staff.~~
~~(2) After a case is referred to the Fraud and Abuse Division, department staff may not attempt to recover funds without prior approval from the Fraud and Abuse Division. Vendor payments may be withheld to coincide with the investigation according to program procedures. If fraud cannot be determined or if the prosecuting attorney declines the case, the attorney general's unit returns the case to the department for administrative sanction or action.~~
~~(3) When provider fraud is suspected, the department makes no agreements for restitution. The decision regarding acceptance of restitution is left to the prosecuting attorney.~~
~~(4) The prosecuting attorney may decide to accept restitution payments before or after an indictment or a court may order a repayment schedule upon conviction. Whether restitution is made instead of a prosecution or following a court order, all cashier's checks or money orders are made payable to the Texas Department of Mental Health and Mental Retardation (TXMHMR).~~
~~(5) The department or its agents are responsible for recoupment when referred cases do not result in prosecution. These cases are returned to the department's Fraud and Abuse Division to send to the appropriate division administrator for administrative action.~~
~~(b) Manner of repayment. When fraud is involved, repayment is arranged based on an administrative hearing, a recommendation by the district or county attorney, or a court order. Claims are collected in one lump sum whenever possible. If the provider is financially unable to pay the indebtedness in this manner, however, payment may be accepted in regular installments. Installment payments should be as large as possible. The claim should be liquidated within one year. Convicted providers should be ordered to make monthly or weekly payments.~~

~~§460.29 Provider Re-enrollment or Provider Contract or Agreement Modification~~

~~(a) No later than September 1, 1999, a provider enrolled in the Medicaid program who wants to continue to participate in the program must, in accordance with instructions from the department, either re-enroll in the Medicaid program under a new contract or agreement approved by the Health and Human Services Commission or modify the provider's existing contract or agreement using language approved by the Health and Human Services Commission.~~
~~(b) A provider enrolled in the Medicaid program who does not re-enroll in the program under the new contract or agreement or modify the existing provider contract or agreement in accordance with the instructions from the department by September 1, 1999, does not retain eligibility to participate in the Medicaid program.~~

~~§460.31 Purpose~~

~~The purpose of this subchapter is to provide public notice of legislatively mandated memoranda of understanding and other agreements between the Texas Department of Mental Health and Mental Retardation (TDMHMR) and other state agencies.~~

~~§460.32 Application~~

~~This subchapter applies to:~~

~~(1) facilities of the Texas Department of Mental Health and Mental Retardation, including Central Office; and~~
~~(2) in the case of §411.62 of this title (relating to Memorandum of Understanding concerning~~

~~§460.33. Definitions~~

~~The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:~~

~~(1) Local mental health and/or mental retardation authority -- As defined in the Texas Health and Safety Code, §531.002, an entity to which the Texas Mental Health and Mental Retardation Board delegates its authority and responsibility within a specified region for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health to persons with mental illness and mental retardation services to persons with mental retardation in one or more local service areas.~~
~~(2) MOU -- Memorandum of understanding.~~
~~(3) TAC -- Texas Administrative Code.~~
~~(4) TDMHMR -- Texas Department of Mental Health and Mental Retardation.~~

~~§460.34. Memorandum of Understanding: Provision, Regulation, and Funding of Services in Hospitals and Long-Term Care Facilities~~

~~(a) TDMHMR adopts by reference a rule of the Texas Department of Human Services (TDHS) contained in 40 TAC §72.101 (relating to Services in Hospitals and Long-term Care Institutions).~~
~~(b) The TDHS rule contains the text of MOU between TDMHMR, TDHS, and the Texas Department of Health concerning responsibilities, procedures, and standards involved in the provision, regulation, and/or funding of services in hospitals and long-term care facilities. The MOU is required by the Texas Human Resources Code, §22.014.~~
~~(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, 909 West 45th Street, Austin, Texas 78756, and may be reviewed during regular business hours.~~

~~§460.35. Memorandum of Understanding: Coordination of Services to Disabled Persons~~

~~(a) TDMHMR adopts by reference rules of the Texas Department of Human Services (TDHS) contained in 40 TAC §§72.201-72.212 (relating to Memorandum of Understanding Concerning Coordination of Services to Persons with Disabilities).~~
~~(b) The TDHS rule contains the text of an MOU between TDMHMR, TDHS, Texas Rehabilitation Commission, Texas Department of Health, Texas Commission for the Blind, Texas Commission for the Deaf, and Texas Education Agency clarifies financial and service responsibilities of each agency in relation to disabled persons and addresses how each agency will share data relating to services to disabled persons. The MOU is required by the Texas Human Resources Code, §22.011.~~
~~(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, 909 West 45th Street, Austin, Texas 78756, and may be reviewed during regular business hours.~~

~~§460.37. Memorandum of Understanding: Coordination of Delivery of Mental Health and Mental Retardation Services to Hearing-Impaired or Deaf Persons~~

~~(a) TDMHMR adopts by reference rules of the Texas Commission for the Deaf and Hard of Hearing (TCDHH) contained in 40 TAC Chapter 181, Subchapter H (relating to Memoranda of Understanding with State Agencies).~~
~~(b) The TCDHH rules contain the text of an MOU between TDMHMR and TCDHH concerning the coordination of delivery of mental health and mental retardation services to persons who are deaf or have a hearing impairment. The MOU is required by the Texas Human Resources Code, §81.017.~~
~~(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, 909 West 45th Street, Austin, Texas 78756, and may be reviewed during regular business hours.~~

~~§460.38. Memorandum of Understanding: Coordination of Exchange and Distribution of Public Awareness Information~~

~~(a) TDMHMR adopts by reference a rule of the Texas Department of Human Services (TDHS) contained in 40 TAC §72.301 (relating to Authorization and Requirement to Exchange and Distribute Public Awareness Information).~~
~~(b) The TDHS rule contains the text of an MOU between TDMHMR, TDHS, Texas Rehabilitation Commission, and Texas Department of Health concerning the coordination of the exchange and distribution of public awareness information among agencies. The MOU is required by the Texas Human Resources Code, §22.013.~~
~~(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, 909 West 45th Street, Austin, Texas 78756, and may be reviewed during regular business hours.~~

~~§460.40. Training Requirements for Identifying Abuse, Neglect, and Unprofessional or Unethical Conduct in Health Care Facilities~~

~~(a) TDMHMR adopts by reference a rule of the Texas Commission on Alcohol and Drug Abuse (TCADA) contained in 40 TAC §148.118 (relating to Training Requirements Relating to Abuse, Neglect, and Unprofessional or Unethical Conduct).~~
~~(b) The TCADA rule contains the text of MOU between TDMHMR, TCADA, and the Texas Department of Health concerning training requirements for identifying abuse, neglect, and unprofessional or unethical conduct in health care facilities. The MOU is required by the Texas Health and Safety Code, §161.133.~~
~~(c) Copies of the MOU are filed in the Office of Policy Development, TDMHMR, 909 West 45th Street, Austin, Texas 78756, and may be reviewed during regular business hours.~~

~~§460.45. Distribution~~

~~The provisions of this subchapter shall be distributed to:~~

~~(1) members of the Texas Mental Health and Mental Retardation Board;~~
~~(2) executive, management and program staff in the TDMHMR's Central Office;~~

~~(3) superintendents/directors of TDMHMR facilities;~~
~~(4) executive directors of all state-operated community services;~~
~~(5) executive directors of all local MHMRAs;~~
~~(6) chairs of boards of trustees of community mental health and mental retardation centers;~~
~~(7) interested advocates and advocacy organizations; and~~
~~(8) state agencies and other entities who are parties to the memoranda referenced in this subchapter.~~

~~§460.51. Purpose~~

~~The purpose of this subchapter is to describe policies and procedures governing audits and investigations in the purview of the Texas Department of Mental Health and Mental Retardation and to serve as the charter for the Office of Internal Audit.~~

~~§460.52. Application~~

~~This subchapter applies to the facilities of the Texas Department of Mental Health and Mental Retardation and contractors and subcontractors.~~

~~§460.53. Definitions~~

~~The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:~~

~~(1) Audit committee--The audit committee of the Texas of Mental Health and Mental Retardation Board.~~
~~(2) Audit--A review of financial, program, or management functions of a facility, contractor, or subcontractor.~~
~~(3) Business entity--A sole proprietorship, including an individual, partnership, firm, corporation, holding company, joint-stock company, receivership, trust, or any other entity recognized by law.~~
~~(4) Commissioner--The commissioner of the Texas Department of Mental Health and Mental Retardation.~~
~~(5) Contract--A written agreement between a business entity and the department that obligates the entity to provide goods or services in exchange for money or other valuable consideration.~~
~~(6) Contractor--A business entity that provides good or services pursuant to a contract.~~
~~(7) Department--The Texas Department of Mental Health and Mental Retardation (TDMHMR).~~
~~(8) Director--The director of Internal Audit.~~
~~(9) Facility CEO--The head of a facility.~~
~~(10) Facility--Any state hospital, state school, state center, Central Office, or entity that may become part of TDMHMR.~~
~~(11) Investigation--The identification and review of allegations of employee misconduct, or other wrong doing involving facilities, contractors, and subcontractors if the alleged activity affects or implicates the integrity of the department's programs, employees, or other functions.~~
~~(12) Staff--Persons who are employed by TDMHMR as auditors or investigators.~~

~~(13) Subcontract--A written agreement between a business entity and a contractor that obligates the entity to provide goods or services in exchange for money or other valuable consideration. (This term includes a "contract" as defined in Chapter 412, Subchapter B, of this title (relating to contracts management for local authorities).~~
~~(14) Subcontractor--A business entity that provides goods or services pursuant to a subcontract. (A "subcontractor" is the same as a "contractor" in Chapter 412, Subchapter B, of this title (relating to contracts management for local authorities.)~~

~~§460.54. Office of Internal Audit Authority and Function~~

~~The Office of Internal Audit, which includes the Office of Investigations, is authorized to conduct audits and investigations of alleged fraud, misconduct, or other wrongdoing involving facilities, contractors, and subcontractors. The director:~~

~~(1) serves at the pleasure of the TDMHMR Board and reports to members of the TDMHMR Board as specified by board policy;~~
~~(2) has access to the commissioner, to whom the TDMHMR Board delegates administrative supervisory responsibilities that do not involve substantive audit issues; and~~
~~(3) is appointed by the commissioner subject to the TDMHMR Board's approval.~~

~~§460.55. Responsibilities of the Audit Committee Chairman and the TDMHMR Board~~

~~(a) The audit committee chairman is responsible for initiating, controlling, and receiving reports on all audit activities involving the Office of the Commissioner.~~
~~(b) The TDMHMR Board is responsible for:~~
~~(1) ensuring the independence of the audit function; and~~
~~(2) notifying the commissioner prior to executing any personnel actions affecting the director.~~

~~§460.56. Responsibilities of the Director~~

~~(a) The director is responsible for recommending to the audit committee chairman audits of the commissioner's office and for providing information that may require an unscheduled audit of the commissioner's office.~~
~~(b) At the audit committee chairman's request, the director is responsible for advising the audit committee chairman on matters relating to the qualifications and selection of independent consulting auditors capable of performing audit activities involving the commissioner's office.~~
~~(c) The director is responsible for submitting through the commissioner to the audit committee for approval:~~
~~(1) the annual audit plan, which is based on risk analyses and identifies the audits to be performed during the year; and~~
~~(2) the Office of Internal Audit annual operating budget.~~
~~(d) As a part of each committee meeting, or as requested by the audit committee chairman, the director is responsible for reporting to the audit committee chairman on the status of the annual audit plan, including exceptions to the timely completion of the annual audit plan; the status of management's resolution of audit findings; and the status of consultations undertaken pursuant to~~

subsection (d) of §411.260 of this title (relating to Scope of Audit Work) involving the Office of Internal Audit.
(e) The director is responsible for informing the commissioner of any issues that come to his or her attention that may adversely affect the department.
(f) The director, at the request of the audit committee chairman, is responsible for providing logistical support services to independent consulting auditors engaged by the audit committee.

§460.57 Access to Records

TDMHMR employees must provide staff with unrestricted access to all TDMHMR employees and records and, if the audit or investigation is extended to include contractor or subcontractor staff or records, the contractors and subcontractors must provide unrestricted access to their staff and records that are relevant to the scope and objectives of an audit or investigation.

§460.58 Standards of Conduct

(a) Staff must be free from personal or external impairments to independence so that opinions, conclusions, and recommendations are impartial and are viewed as such by knowledgeable third parties.
(b) Staff must ensure that confidential information acquired during the course of an audit or investigation remains confidential to the extent permitted by law as a condition of employment.
(c) Staff must not use any information obtained in an audit or investigation for any personal gain.

§460.59 Standards for Conducting Audits and Investigations

Audit and investigation activities must be conducted in accordance with the most recent edition of the:

(1) Standards for the Professional Practice of Internal Auditing , The Institute of Internal Auditors, Inc.;
(2) Standards for Audit of Governmental Organizations, Programs, Activities and Functions, the Comptroller General of the United States, as applicable;
(3) Code of Ethics of the Institute of Internal Auditors, Inc.;
(4) Statement of Responsibilities of Internal Auditing of the Institute of Internal Auditors, Inc.;
(5) Standards and Code of Ethics of the Association of Certified Fraud Examiners, Inc.; and
(6) Internal Auditing Act, Texas Government Code, Chapter 2102.

§460.60 Scope of Audit Work

(a) Facilities or activities are audited as described in the annual audit plan. During an audit, staff may identify issues that result in extending the scope of the audit. While onsite, the senior auditor provides the facility, contractor, and subcontractor's CEO with a completed interim audit finding form for each finding and recommendation and requests a response on each audit finding form for purposes of discussion at the exit conference unless the site auditor has reason to believe that fraud, misconduct, or other wrongdoing is involved. The scope of an audit may include one or more of the following.

~~(1) Staff may evaluate the efficiency and economy of management operations as described in the department's rules, policies, procedures, and performance contracts, and the systems of internal control and the quality in performing assigned responsibilities at each facility, which includes:~~

~~(A) planning the audit, examining and evaluating operations, communicating results, and following up on recommendations within the limits of budgetary constrains, time available, and the significance of the findings;~~

~~(B) reviewing the reliability and integrity of financial and operating information and the means used to identify, measure, classify, and report such information;~~

~~(C) reviewing the system established to ensure compliance with those policies, plans, procedures, laws, and regulation that could have a significant impact on operations and reports;~~

~~(D) reviewing the means for safeguarding assets and, if appropriate, verifying the existence of assets;~~

~~(E) appraising the economy and efficiency with which resources are employed;~~

~~(F) reviewing operations to ascertain whether results are consistent with established objectives and goals and whether the activities are being implemented as planned;~~

~~(G) evaluating the internal management controls of the department's automated systems during the planning, design, installation, and production phases of the system; and~~

~~(H) evaluating the internal and management controls of the department's new programs during development, implementation, and operational stages.~~

~~(2) Staff cannot exercise direct authority over facility, contractor, or subcontractor employees who are subject to the audit or investigation.~~

~~(3) Audit and investigation activities do not relieve employees responsible for the activities subject to the audit or investigation from the responsibilities assigned to them.~~

~~(b) Staff independently conclude on the results of the audit, issue a final report to the board and the commissioner identifying significant deficiencies or instances of noncompliance, and recommend corrective action and/or economy and efficiency improvements for the audited facility, contractor, or subcontractor.~~

~~(c) If approved by the board or the commissioner, staff investigate alleged fraud, misconduct, or other wrongdoing in accordance with §411.265 of this title (relating to Investigating Alleged Fraud, Misconduct, or Other Wrongdoing).~~

~~(d) The director may consult the board, the Office of the Governor, the State Auditor's Office, and other legislative agencies or committees concerning matters affecting audit duties or responsibilities.~~

~~§460.61. Exit Conference Procedures for Audits~~

~~At the conclusion of the audit, staff conduct an exit conference that includes the CEO and administrative staff of the audited facility, contractor, or subcontractor to discuss the exceptions and recommendations noted on the interim audit finding forms. An attempt is made to resolve all exceptions at the facility, contractor, or subcontractor level before writing the final audit report. Regardless of whether significant issues are resolved during the exit conference, they may be included in the final audit report.~~

~~§460.62. Responses to Audit Findings~~

~~Within 10 working days of the exit conference, the CEO of the audited facility, contractor, or subcontractor or designee (respondent) submits to the deputy commissioner for Community Programs, deputy commissioner for Finance and Administration, director of State Mental Health Facilities, or director of Mental Retardation Facilities, as appropriate, his or her responses to the audit findings. A subcontractor must also submit a copy of the audit responses to the contractor. The respondent to the final audit report must describe the actions to be taken regarding each exception and recommendation noted on the audit finding forms. The deputy commissioner for Community Programs, deputy commissioner for Finance and Administration, director of State Mental Health Facilities, or director of Mental Retardation Facilities must submit to the director the final approved responses to audit findings.~~

~~§460.63 Final Audit Report Distribution~~

~~(a) Within 60 calendar days of the exit conference, the director issues the final audit report according to the reporting requirements.~~
~~(b) Final audit reports for all audits of facilities, contractors, and subcontractors are forwarded to the commissioner and distributed to the deputy commissioner for Community Programs, deputy commissioner for Finance and Administration, director of State Mental Health Facilities, or director of Mental Retardation Facilities; and other staff, as appropriate. The deputy commissioner or director, as appropriate, is responsible for disseminating the final audit report to appropriate facility employees and contractors, and contractors are responsible for disseminating the final audit report to their employees and subcontractors.~~
~~(c) Each member of the TDMHMR Board receives a copy of all final audit reports.~~

~~§460.64 Implementing Audit Recommendations~~

~~The facility, contractor, or subcontractor CEO or designee is responsible for implementing the actions taken in response to the audit findings described in §411.262 of this title (relating to Responses to Audit Findings).~~

~~§460.65 Investigating Alleged Fraud, Misconduct, or Other Wrongdoing~~

~~(a) Receiving a complaint or identifying alleged wrongdoing. If staff receive a complaint or identify alleged wrongdoing and report it to the director or designee, the director may request additional information to determine whether an investigation is warranted.~~
~~(b) Determining investigative action. If the director or designee determines that an investigation:~~
~~(1) is warranted, then the director or designee prepares a written summary of the allegation, including supporting documentation. The summary and the director's investigative recommendation is submitted to the commissioner or the TDMHMR Board for approval.~~
~~(2) is not warranted, then the file is documented as closed and remains under intake status to support such action.~~
~~(c) Approving an investigation. If the commissioner or TDMHMR Board:~~
~~(1) approves the investigation and, if during its course it becomes apparent that the alleged wrongdoing occurred or may be ongoing, the director or designee advises the commissioner or TDMHMR Board who determines whether to refer the matter to the law enforcement authority; or~~

~~(2) does not approve the investigation, then the file is documented as closed and remains under intake status to support such action.~~

~~(d) TDMHMR employee confidentiality. Staff must ask TDMHMR employees who are interviewed or who are included in briefings concerning investigation activities to sign a confidentiality agreement regarding the information presented or discussed. If a TDMHMR employee signs a confidentiality agreement, the employee is agreeing to maintain such confidentiality to the extent permitted by law. If an employee refuses to sign the confidentiality agreement, then, in accordance with department policy, the employee may be subject to disciplinary action as determined by the facility CEO.~~

~~(e) Conducting the investigation.~~

~~(1) If the investigation involves the commissioner's office, the director or designee immediately reports any investigative impediments to the TDMHMR Board's audit committee chairman.~~

~~(2) If staff conducting the investigation determine that the department may be at risk or liable under the law, the director or designee must be notified as soon as practical.~~

~~(3) Staff, as appropriate to the circumstances of the investigation, notify the CEO or governing body of such facility, contractor, or subcontractor, that an investigation is being conducted, including the contractor of a subcontractor under investigation.~~

~~(4) If facility, contractor, or subcontractor administration is considering personnel action based upon information obtained during an on going investigation, he or she must contact the director or designee before taking the personal action so the potential impact on the investigation can be evaluated.~~

~~(5) If the personnel action is taken, facility, contractor, or subcontractor administration must notify staff conducting the investigation.~~

~~(f) Referring to law enforcement authorities. If the matter under investigation:~~

~~(1) is referred to law enforcement authorities:~~

~~(A) the lead investigator makes the referral.~~

~~(B) staff act as the liaison between the department and law enforcement authorities.~~

~~(C) staff may assist in the investigation under the direction of law enforcement authorities.~~

~~(2) is not referred to law enforcement authorities:~~

~~(A) the commissioner or board may direct staff to further investigate.~~

~~(B) the case may be closed without further action and filed under intake status to support such action.~~

~~(3) is declined by law enforcement authorities:~~

~~(A) the commissioner or board may direct staff to further investigate.~~

~~(B) the case may be closed without further action and filed under intake status to support action.~~

~~(g) Briefing executive staff. The director or designee must offer to brief the commissioner and the TDMHMR Board. As appropriate to the circumstances of the investigation, the director or designee may brief the CEO or governing body of the facility, contractor, or subcontractor verbally on the status of the investigation and, upon completion, provide the final written report. Verbal status reports and final written reports assist executive staff in:~~

~~(1) administering personnel action;~~

~~(2) referring to law enforcement;~~

~~(3) revising rules, policies, and procedures;~~

~~(4) implementing performance reviews; and~~

~~(5) enforcing contractual obligations.~~

(h) Documenting investigative results. The lead investigator must prepare the final written report documenting the results of the investigation, including:
(1) a statement of allegations;
(2) a summary of investigation activities;
(3) an analysis of the evidence;
(4) a statement indicating whether fraud, misconduct, or wrongdoing occurred; and
(5) the recommended course of action.

§460.66 References

Reference is made to the following rules, statutes, and publications:

(1) Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, the Comptroller General of the United States;
(2) Standards for the Professional Practice of Internal Auditing, The Institute of Internal Auditors, Inc.;
(3) Code of Ethics of the Institute of Internal Auditors, Inc.;
(4) The Statement of Responsibilities of Internal Auditing of the Institute of Internal Auditors, Inc.;
(5) Internal Auditing Act, Texas Government Code, Chapter 2102; and
(6) Standards and Code of Ethics of the Association of Certified Fraud Examiners, Inc.

§460.67 Distribution

(a) This subchapter is distributed to members of the TDMHMR Board and executive, management, and program staff of Central Office.
(b) This subchapter is distributed to all facility CEOs who are responsible for disseminating this subchapter to their staff, as appropriate.
(c) This subchapter is distributed to contracts management staff who are responsible for disseminating this subchapter to all appropriate contractors. Contractors are responsible for disseminating this subchapter to all appropriate subcontractors.

§460.101 Procurement

(a) The Commission shall procure all goods and services in compliance with 1 TAC ch. 391 (2003).
(1) Procurements will be classified as either formal or informal, based on the estimated dollar value of the transaction. Dollar thresholds will be established in Commission policies and procedures, and the methodology will be reviewed annually.
(2) The Commission may use a waiver process as defined in 1 TAC ch. 391 (2003) for procurements below $100,000. The waiver process may be used in the presence of unique circumstances related to that procurement action. All waivers will be approved by the executive director.
(3) Procurement of prevention, intervention, treatment and related support services shall be conducted as described in ch. 144 of this title (relating to Contract Administrative Requirements).

(b) The Commission requires compliance with the Historically Underutilized Businesses rules published by the Texas Building and Procurement Commission in 1 TAC ch. 111 (2003).
(c) Procurement personnel, vendors, contractors, and suppliers will adhere to standards of conduct established in Commission policies and procedures. These standards shall be at least as restrictive as standards of conduct for State officers and employees under applicable State and Federal law.

§460.102. Procurement Protests

(a) An offeror may request an informal review of a tentative purchase award if:
(1) the offeror was not selected in a competitive procurement;
(2) the procurement was a sole source or emergency procurement; or
(3) the procurement was made under an executive director waiver.
(b) The protest must be limited to issues relating to the offeror's qualifications, the suitability of the goods or services offered by the offeror, or alleged irregularities in the procurement process.
(c) A procurement review request must be submitted in writing and received by the Commission no later than 30 calendar days after the date of the award, except for protests alleging irregularities involving standards of conduct on the part of Commission employees or selected vendors, which must be received by the Commission no later than 90 calendar days after the date of the award.
(d) The protest process shall be carried out in accordance with Commission policies and procedures, which include documentation standards.
(e) A procurement protest shall not be conducted as a contested case under the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 (Vernon 2000 & Supp. 2004).
(f) The Commission shall not award a contract for a protested procurement until the Commission has provided the protesting offeror with a written response. The Commission may waive this requirement for exigent circumstances or when an award required by State or Federal law must be completed by a particular date.

§460.103. Public Comment and Requests

At its public meetings, the Commission may receive public comment from any person on any issue which is not otherwise provided for by rule or procedure. The Commission may limit public comment to five minutes per person. The Commission shall maintain a list of visitors attending public meetings.

§460.104. Approval Authority

(a) The executive director and the executive director's designees shall have authority to enter into contracts or approve vouchers for payment from funds appropriated to the Commission.
(b) The Commission members shall approve budget requests to be submitted to the legislature and shall approve the agency's budget of appropriated funds and funds from other sources.

§460.105. Training and Education
Commission policy establishes eligibility requirements and employee obligations for training and education supported by the agency.